DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 30, 2025

Licensee
Abundance Home Care LLC
6248 Sunrise Terrace
Brooklyn Park, MN 55428

RE: Project Number(s) SL41269015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 24, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s)

identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41269	A. BUILDING: _____ B. WING _____	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABUNDANCE HOME CARE LLC	6248 SUNRISE TERRACE BROOKLYN PARK, MN 55428

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL41269015-0 On September 22, 2025, through September 24, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

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0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 22, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A provided the	0 485		

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0 485	Continued From page 2 surveyor with a blank copy of the licensee's assisted living contract and stated it was the same contract utilized by all residents. The provided assisted living contract indicated that meals were included in the basic monthly fee. On September 23, 2025, at 2:56 p.m., LALD-A stated they were responsible for the development of the licensee's contract. On September 24, 2025, at 1:47 p.m., LALD-A stated an updated contract was developed prior to survey in which the language was changed to remove inclusion of meals in basic monthly fee, but the contract had not been distributed to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 700		

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0 700	Continued From page 3 review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 22, 2025, at 12:57 p.m., the surveyor observed a calendar posted on the licensee's main posting board, which was located in a common area utilized by all residents and visitors. The calendar dated September 2025, contained the name of R3 and the time and date of appointments as well as the name of the specific types of radiation treatments R3 was receiving. On September 23, 2025, at 3:02 p.m., clinical nurse supervisor (CNS)-B stated the calendar was used by staff to provide reminders to R3 on upcoming appointments. The licensee's Data Privacy & Record Retention Policy dated December 1, 2024, indicated the licensee would maintain accurate complete, and confidential records for all residents and staff and access to these records would be restricted to authorized personnel. No further information was provided.	0 700		

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0 700	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 5 The findings include: On September 23, 2025, at 12:15 p.m., surveyor toured the facility with clinical nurse supervisor (CNS)-B and the following was observed: Black stains were found on the wall under the utility sink in the basement caused from moisture. CNS-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 6 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2025, at 12:45 p.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN:	0 810		

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0 810	Continued From page 7 The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee and resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was a general guidance for fire response including responding the RACE systems but did not provide specific employee and resident actions to take in the event of a fire or similar emergency geared to this facility. The FSEP also included smoke compartment doors and that sprinklers would activate in the event of a fire which this facility was not equipped for. LALD-A stated that they understood what was lacking in this plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced	0 910		

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0 910	Continued From page 8 by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On September 22, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A provided the surveyor with a blank copy of the licensee's assisted living contract and stated it was the same contract utilized by all residents. The licensee's contract lacked documentation in a conspicuous place and manner the managing agent of the facility, if applicable, and the authorized agent for the facility. On September 24, 2025, at 1:41 p.m., LALD-A stated they had created the licensee's residents' contract as a generic form, and was not aware the contract needed to list the authorized agent of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		

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0 940	Continued From page 9	0 940		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940		

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0 940	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents residing within the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 22, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A provided the surveyor with a blank copy of the licensee's assisted living contract and stated it was the same contract utilized by all residents. The licensee's contract lacked documentation of a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided, and; - whether the facility requires a resident to pay privately for a period of time prior to accepting	0 940		

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0 940	Continued From page 11 payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. On September 24, 2025, at 1:43 p.m., LALD-A stated they were unaware of these required contract components. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident	0 950		

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0 950	Continued From page 12 must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 22, 2025, at 11:30 a.m., licensed assisted living director (LALD)-A provided the surveyor with a blank copy of the licensee's assisted living contract and stated it was the same contract utilized by all residents. The licensee's contract lacked an opportunity to designate a representative and the verbatim "right to designate a representative for certain purposes" notice. On September 24, 2025, at 1:44 p.m., LALD-A stated they were not aware of the requirement.	0 950		

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	41269	A. BUILDING: _____ B. WING _____	09/24/2025

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0 950	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of one unlicensed personnel (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01380		

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01380	Continued From page 14 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C was hired December 20, 2024, to provide assisted living services. ULP-C's record contained range of motion trainings that had been completed on Educare (an online training resource). ULP-C's employee record lacked documentation of having completed range of motion and positioning competencies. On September 23, 2025, at 7:44 a.m. to 8:36 a.m., the surveyor observed ULP-C provide assisted living services to residents residing within the facility. On September 24, 2025, at 2:57 p.m., clinical nurse supervisor (CNS)-B stated the licensee did not provide range of motion and positioning for residents, so staff had not been trained in on the tasks. The licensee Competency and Performance Evaluation Policy dated December 1, 2024, indicated the licensee would establish procedures for evaluating staff competency and performance to ensure all employees possess the knowledge, skills, and abilities required to safely and effectively provide resident care in compliance with Minnesota Statutes 144G and related MDH regulations. No further information was provided.	01380		

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01380	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for	01530		

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01530	Continued From page 16 consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: CNS-B was hired June 19, 2024, to provide clinical oversite and assisted living services. CNS-B's employee record indicated CNS-B had only completed 0.75 hours of the required two hours of mental health training. On September 23, 2025, CNS-B stated they were aware of the required mental health training and had assigned these trainings to themselves but had not yet completed the required trainings due	01530		

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01530	Continued From page 17 to time constraints. The licensee's policies did not address the new statutory requirement to provide mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned	01650		

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01650	Continued From page 18 consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the service plan contained all required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on January 10, 2025, to receive assisted living services. R2's diagnosis included Huntington's chorea, bipolar disorder, depression, and hypertension. R2's service plan dated January 10, 2025, indicated R2 received assistance with medication management, mental health monitoring, and assistance with dressing, grooming, toileting, and personal hygiene. R3 R3 was admitted December 11, 2024, to receive assisted living services.	01650		

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01650	Continued From page 19 R3's diagnosis included chronic pain, COPD, and hyper extended discs. R3's service plan dated December 12, 2024, indicated R3 received assistance with medication management, mental health monitoring, and assistance with dressing, grooming, toileting, and personal hygiene. R2 and R3's service plan lacked the following required components: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On September 23, 2025, at 3:19 p.m., clinical nurse supervisor (CNS)-B stated they were not aware the service plans required the above information. The licensee's policy titled Service Plan Development & Review Policy, dated December 1, 2024, indicated the licensee would have in place an individualized service plan based on their current assessment, in compliance with Minnesota Statutes 144G.42 and MDH requirements. No further information was provided.	01650		

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01650	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730		

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01730	Continued From page 21 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on January 10, 2025, to receive assisted living services. R2's diagnosis included Huntington's chorea, bipolar disorder, depression, and hypertension. R2's service plan dated January 10, 2025, indicated R2 received assistance with medication	01730		

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01730	Continued From page 22 management, mental health monitoring, and assistance with dressing, grooming, toileting, and personal hygiene. R2's medication management plan dated January 12, 2025, lacked the following required information: - medication management tasks that may be delegated to unlicensed personnel (ULP), and; - procedures for staff to notify a registered nurse (RN) when problems arose. On September 23, 2025, at 7:56 a.m., the surveyor observed R2 recieve medications adminsitered by ULP-C. R3 R3 was admitted December 11, 2024, to receive assisted living services. R3's diagnosis included chronic pain, COPD, and hyper extended discs. R3's service plan dated December 12, 2024, indicated R3 received assistance with medication management, mental health monitoring, and assistance with dressing, grooming, toileting, and personal hygiene. R3's medication management plan dated December 13, 2025, lacked the following required information: - type of medication storage system, based on resident's needs; - procedures for staff to notify an RN when problems arose, and; - medication administration delegated to unlicensed personnel and documented resident specific instructions.	01730		

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01730	Continued From page 23 On Septeber 23, 2025, at 8:35 a.m., the surveyor observed R3 recieve medications adminsitered by ULP-C. On September 23, 2025, at 3:23 p.m., clinical nurse supervisor (CNS)-B stated they had developed the templated medication management plan, and the missing information was omitted due to a knowledge deficit. The licensee's policy titled Medication Management Policy, dated December 1, 2024, indication the licensee would develop a written a written medication management system that covers medication storage, setup, administration, documentation, disposal, and error reporting which would be in compliance with Minnesota Statutes§ 144G.71, MDH regulations, and current nursing standards of practice. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time	01890		

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01890	Continued From page 24 sensitive medications were labeled with the date opened for one of three residents (R3), and failed to ensure expired medications were disposed of. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 23, 2025, at 8:05 a.m., during an audit of the licensee's secured medication closet, the surveyor observed the following: - Trelegy Ellipta inhaler belonging to R3 with no opened-on date; and - package of Mucinex Fast-Max Cold & Flu stored as a stock medication with an expiration date of August 2024. The manufacturer's label printed on the back of the undated Trelegy Ellipta inhaler belonging to R3 indicated the medication should be discarded six weeks after opening the tray or when the counter reads "0". On September 23, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-B stated they were not in the practice of labeling time sensitive medications and would typically just dispose of medications on their expiration date. The licensee's Storage and Control of Medications dated June 1, 2024, indicated the licensee would ensure the secure, organized, and	01890		

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01890	Continued From page 25 compliant storage of all medications in accordance with Minnesota Department of Health regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

ABUNDANCE HOME CARE LLC
6248 SUNRISE TERRACE
Brooklyn Park, MN 55428
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41269

Risk:
License:
Expires on:
CFPM: Gregory Slah
CFPM #: 58522; Exp: 05/15/2028

Inspection Info

Report Number: F1051251113
Inspection Type: Full - Single
Date: 9/22/2025 Time: 11:30:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, ZACHARY MORTH.

DISCUSSED THE FOLLOWING WITH THE FACILITY MANAGER, EMMA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HANDWASHING & GLOVE USE/DISPOSAL
HIGHLY SUSCEPTIBLE POPULATION

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1051251113 from 9/22/2025

Emma
Facility Manager

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

ABUNDANCE HOME CARE LLC
Brooklyn Park
County/Group: Hennepin County

Inspection Info

Report Number: F1051251113
Inspection Type: Full
Date: 9/22/2025
Time: 11:30:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Ambient Air
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No